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ABSTRACT

In this 1975 Oration of the Society for Health and Human Values, the author, an international medical educator, reviews the changing attitudes to human values in medical education as experienced at the London Hospital Medical College. Proposed is a broad, general approach to the whole patient, socially and behaviorally as well as biologically and pathologically, and stressed is the need to place less emphasis during the undergraduate years of medical education on specialization based on diseased organs and more on individuals and what they seek from life. (BT)

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HUMAN VALUES IN MEDICAL EDUCATION

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Special Number of the Society for Health and Human Values

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HUMAN VALUES IN MEDICAL EDUCATION

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FOREWORD

A common interest in medical education with concern for teaching of human values drew together the group that founded this Society. Traditionally, teaching of classical disciplines in the humanities formed the basis for the education of university students, especially those who were preparing to enter professions. In the evolution of the current programs in medical education, this emphasis steadily has been reduced in favor of that in the natural sciences.

The spectacular success of research in the sciences drastically has reduced deaths from the infectious diseases and displaced them as the leading causes of death. The importance of the life-style of patients in the causation of the chronic illnesses that replaced these diseases only recently has been receiving serious attention. We have no cure for cancer, heart disease, stroke, diabetes, and other diseases that is comparable to the chemotherapy of infections. Indeed, we lack the basic biologic information on their causes, so must turn more to circumstantial than scientific evidence. If begun early, alteration of a harmful life-style can prevent the development of many chronic illnesses. Unfortunately, changes instituted later in life after the diseases are apparent have little effect and may only delay the progression of fatal complications. The life-style of the patient is dependent on the human values held by him. Often they are in conflict with those of the physician and his recommendations for health care. The failure to follow a prescribed regime leads to frustration on the part of the doctor who must learn to take a more philosophic approach which often he finds hard to accept.

The British experience with multidiscipline education reflects the organization and importance of the colleges in the university.

Dr. Ellis has described it from the point of view first as a student and now as a dean. Students are exposed to dedicated teachers serving as tutors who start the process of lifelong learning. In medical education, the emphasis on treatment of patients applied scientific knowledge gained in the study of organic diseases. This approach resulted in the training of superb clinicians. The detection of pathologic processes by meticulous, skillful physical examination is a distinctive British contribution. In other countries, increasing emphasis on the importance of the history with probing into the background and life-style of the patient began to bring out the conflict of personal values with the pressures of modern society. A broad general approach to the whole patient, socially and behaviorally as well as biologically and pathologically, should lead to less emphasis during the undergraduate years of medical education on specialization based on diseased organs and more on individuals and what they seek from life.

The Society for Health and Human Values serves as a catalyst to bring together educators and practitioners of different backgrounds and interests to promote the attainment of excellence in medicine. The Society has no official responsibilities in the process of accrediting medical schools, in setting standards for curricula, the selection of students, or the organization of health center administration. It tries to encourage faculty to help students learn about life as reflected in the actions of people in the real world they will face in practice and not to look solely from the sheltered view of their own home background and former schools. All health professionals must learn to recognize and appreciate the values held by the people they serve so that the good health of their patients can be maintained and improved.

GEORGE T. HARRELL, M.D.

President, 1975
Society for Health and Human Values

Timonium, Maryland
1976

Human Values in Medical Education

I can show my gratitude for the privilege of being here, the pleasure of being again with many old friends, and the honour of being invited to give this Oration, an honour which I take as a very personal one, only in a personal way by sharing with you my personal thoughts on human values and medical education. My own attitudes and values, I suppose, have been laid down long ago, to some extent before I was, have been affected, or not affected as the case may be, by the circumstances in which I have lived. This discourse is therefore necessarily to some extent autobiographical and very largely related to Britain. For the autobiographical aspects I apologise in advance. So far as speaking about Britain is concerned, there is perhaps in 1975 some obligation to show you what you have missed, to show what you might now be enjoying had events taken a slightly different course 200 years ago.

I went to University at the age of eighteen, in the early 1930's. Since selection for medicine was not competitive, no one asked me why I wanted to be a doctor. If they had I would have said I wanted, by applying what medicine had to offer, to help make sick people better. I was not very sure what medicine had to offer, but I understood that, whatever it was, apart from comfort, it would be applied physically, by the hands. I thought there were a great many people who would benefit from that. I thought it wrong that so many people seemed to have so little chance of avoiding disease. I felt strongly that they should have greater opportunity for health, but I could not see any clear role for a doctor in achieving that aim, certainly none that I myself was anxious to play. I had no great interest in any of the sciences; none at all in any kind of research. I do not think my motivation differed greatly from that of most of my contemporaries.

We all resembled each other in other ways also. While being by no means drawn from just one section of society, our earlier education had been on similar lines, both as regards content and method. Though not all had experienced the rigours of English boarding-

school life, the attitudes engendered by it in people of our kinds of temperament tended to predominate, particularly a rather tolerant acceptance of discipline and a readiness to serve. At the same time we were conscious of the then public image of medical students, as cheerful extraverts, wholly irresponsible in play—learning to be kind, practical doctors by daily apprenticeship and recurrent episodes of intense "swotting." Most of us had leaned increasingly, if not exclusively, towards the study of basic sciences in our last years at secondary school although for most, chemistry, physics, and biology were the content of a first, premedical, year at University, completed by passing a First M.B. examination.

Cambridge University, to which I went myself, just had decided to take only those who had already completed the study of those subjects, but the standard required was not very high. It was within the reach of anyone who up to the age of sixteen or seventeen had studied virtually no science at all. I myself came to science for the first time some two years after obtaining my matriculation, or basic university entrance, in the interim having enjoyed greatly the study in depth of history and English at what we call the Sixth form level, with teachers who achieved their desire to share with me their delight in those subjects.

The Cambridge University departments in the basic medical sciences were of a high academic level. The course of three years was unhurried. It had no clinical connection—I never saw a patient, nor, I think, a practising doctor—and no very obvious vocational orientation, but I do not remember any of us seriously questioning its relevance to the future practice of medicine. Perhaps we never looked beyond the fact that it was intrinsically interesting. Anyway, it was set in a context that allowed us to enjoy most of the pleasures of the young in a small town liberally endowed with evidence of man's past achievements, while set aside from sight and sound of the miseries of the world around us.

Cambridge University is a federation of autonomous Colleges, each consisting of Fellows and Scholars, or staff and students, drawn from all the different faculties or disciplines. The undergraduate follows a course of studies designed and implemented by the University, but he is responsible to a College that is itself responsible for his personal and academic development. It is impossible for him not to be affected by buildings of great beauty in which have been collected and preserved treasures from many

generations, not on show but a natural part of a living organisation that over centuries has pursued much the same educational purpose in constantly changing ways. He has the pleasure and advantage of living and studying with students of other subjects, but there is nothing unusual about that. The peculiar advantage of Cambridge is that the student relates most, and most closely, to staff who themselves belong to a multifaculty organisation and are themselves enabled and indeed required to be in continuing contact with teachers and workers in other disciplines. The Cambridge undergraduate has the opportunity of contact, in the most pleasant and civilised ways, with men of quality and distinction in a variety of widely different fields, whose interest in him stems only from the fact that he and they are members—albeit senior and very junior—of the same University. It is not difficult to sense that the University exists as much for a joint attack on unsolved problems, including the most imponderable, by old and young together, as it does for the transmission of knowledge from the one to the other.

I left Cambridge with the conviction that educational institutions are organisms that have an existence over and above that of the people who run them, give to them, or take from them, at any one time. They exist, as it were, in their own right, and those of whom they are made up in each era hold them in trust, charged with the duty of adapting them to changing conditions. I believe this to be true and important. As the Dean of a medical school, I have found this concept comforting.

I was convinced also and have remained convinced ever since that close contact between University teachers of different disciplines is considerably more important than a similar mixing of students. I have remained convinced also of the immense value of extracurricular, informal contacts between students and teachers, preferably teachers of diverse disciplines, and of the system of academic tutoring in which the purpose of the tutor is not to teach but to assist the learning and academic development of the student. I consider the improvement of this tutorial system in my own school to be one of the most important of my duties.

Furthermore, I left Cambridge under the impression, which rightly or wrongly has not left me, that I had been privileged to meet a number of people whom I, and in some instances the world also, classed as great. They differed from each other in many ways—in their subjects, in achievements, likes, dislikes, and appear-

ance. They resembled each other in having trained intellects, integrity, humility, discrimination, a concern for humanity, and a belief that the future can be influenced by man. Although some were scientists and some were not, I failed to glimpse two cultures and saw only one. They postulated no scale of human values in any formal fashion—but they influenced mine.

When I began my three-year clinical course at The London Hospital I had not read the description of it published by Flexner some ten years earlier. I do not think many of my teachers had either. It was, however, exactly as he described. We students came to the wards as informed apprentices, who by virtue of previous training were soon capable of orderly procedure in the analysis of symptoms, the arrangement of data, the drawing of tentative conclusions. Incorporated into firms we were made part "of the functioning machine." We learned medicine "by seeing it practised and by increasing participation in its details." Our teachers were, with few exceptions, "intent on practising medicine and training men who will at once be at home with patients, rather than men equipped to keep pace with, or contribute to, the rapid development of clinical science." We were programmed to deal in a particular way with each of a number of recognisable clinical situations. There was some flexibility in the course, but little encouragement of originality. Teaching was authoritarian; critical discussion did not take place. The clinical teacher, and, indeed, the student, did live "within the circle of the immediate, the technical, the practical."

The practical doctor labelled the patient's condition and applied or prescribed the remedy currently thought appropriate to the label. Attempts to probe further, to understand more, and in consequence to be more effective, tended to be described as "scientific" and to be looked upon somewhat askance. As Flexner had noted, no one then dared "roundly assert in Great Britain that practical and scientific are identical." He was correct too that those students who came from Cambridge to London soon "succumbed to the prevailing viewpoint—that of structural and morbid anatomy." The post-mortem room was not only the palace of truth, but of the whole truth. Medicine was concerned with organic disease.

Our teachers were immensely concerned for their patients, provided they had organic disease. They were punctilious in their

attendance, determined to maintain a high standard of care for the individual and to inculcate a high standard in us. They demonstrated and demanded rigorous bedside clinical method, especially of physical examination. The history was less important, and though personal and social histories were encouraged by some physicians, they were discouraged by most surgeons. Outside the special senses, there was almost no specialisation.

Our teachers were interested in us students and at pains to know us through numerous extracurricular activities. In the wards, outpatient clinics, and operating theatres, they incorporated us into their practice. They practised in full view of us, as they taught us in full view and hearing of all patients. In this strange open arena, sympathy, compassion, and caring were shown, perhaps more by deeds than words. Privacy did not exist. One to one relationship, between doctor and patient, or teacher and student, operated in public. Explanations to patients, or to students, were rare. Statements, dictates—to both—were common and noticably comforting. There was never any doubt that the patients came first no matter who they were. The purpose of everyone else was to give the patients the highest possible standard of care. In this aim all staff were united into a tightknit little team—in which, I might add, the ward sister carried much responsibility for ensuring that students made their proper contribution in an appropriate way.

The patients were in receipt of charity. The doctors gave their services. Their life-styles were wholly different, yet each could visualise so clearly that of the other that mutual understanding appeared to exist. Names were seldom exchanged. Patients were most commonly addressed as Mr. or Mrs., "Mother" or "Dad." Yet the overwhelming impression made on us students by the doctors and nurses to whom we were attached was, I think, that they cared about sick people—cared about them equally, quite irrespective of who or what they were. The London Hospital had had as its motto a line from Terence "*Homo sum, nihil humani a me alienum puto.*" "I am a man, nothing that is human is alien to me." Terence is still taken seriously, but he was taken seriously in those days primarily in regard to anyone who sought help from The London who had evidence of organic disease. The absence of such evidence led rapidly to loss of patient status, to reclassification as "functional," and prompt referral back to the outer world, with an indication that medicine could offer little if any help for such

troubles, as well as some suggestion on occasion that they were, if not the would-be patient's own fault, at least his own responsibility. I wonder sometimes whether doctors thirty or forty years ago were quite so warm, kind, and understanding as they are now said to have been.

Since that time, of course, medicine has passed through a revolution. Largely, but not entirely, because of the greater application of science it ceased to be concerned solely with the physical aspects of disease. It became concerned with disorders of function, of body and of mind, as well as with disorders of structure. It became more concerned with people and less with diseases. It became holistic, requiring in more and more clinical situations account to be taken of all factors involved—physical, chemical, psychological, and social—not least because its increased capacity to help was accompanied by an increased ability to harm either the individual or society or both. Medicine became personal, but at the same time became at one extreme so simple that appropriate action can be taken by rule of thumb, and at the other so complex that a doctor alone can safely do little without time, thought, and the collaboration of other doctors and health workers. The success of much treatment depends not only on very precise diagnosis, but also on the careful monitoring of progress. Much of medicine has become dependent on teamwork, on equipment, facilities, and purpose-built premises.

Not surprisingly personal medicine is difficult to practise and very difficult to practise well. Much more knowledge, skill, and experience are required to obtain an accurate history than to make an accurate physical examination. Weighing of evidence that ranges from objective to subjective calls for considerable judgment. Teaching personal medicine is not particularly difficult, but learning and acquiring competence in it takes time. For a number of reasons it is no longer possible to rely on the system by which organic medicine was so successfully taught up to thirty or forty years ago.

Because it is holistic, personal medicine requires the gathering of information on all aspects of the patient, frequently involving teamwork, and that information cannot be put together, analysed, and interpreted in front of the patient. He is, therefore, unaware of the care that is being given to consideration of his problems. He well may go without any news at all for some time. When he does

receive news, he is given a prepared digest, which to his surprise and dismay is more likely to be a description of a person, himself, than the name of a disease. It is paradoxical, but it seems to be true, that while patients wish to be treated as people, they prefer to be spoken to about disease. They would rather be told what they have got than how they are, though some perhaps are anxious only to know what they have not got, willingly leaving whatever they have to their doctor to look after. It is really not surprising that people often are very satisfied with what the doctors, and the word is commonly in the plural, have done, and yet are disappointed with what they have said, often to the point of believing that they have said nothing of any relevance at all. It could be that doctors are thought to be cold and calculating because in order to practise personal medicine well they have to make some very cold calculations.

There is much more that could be said about the adaptation of medical education to contemporary medicine, including reference to the translation from the medical school course to the later years of training, of much that has to do with the care of the individual. But I do not believe that it is in relation to the care of this individual alone that all the problems of human values in relation to medical education are located. In any case whatever educational changes we make must be related to the kinds of students we have.

It is my belief that the practice of medicine in Britain today, and certainly hospital medicine, is far more holistic and personal than it was forty years ago. Doctors are as caring as they have ever been, but they are now much more concerned with the patient and much less with the disease, especially and rightly when they are generalists. Students are infinitely better informed about people, individuals, groups, and communities than we were, not simply because of the introduction of more formal teaching in sociology, psychology, and psychiatry, nor because at secondary school they have been less restricted than at earlier times to the study of basic sciences.

It could be that doctors bring less comfort than they did because they are less dogmatic, less certain. At the same time the patient firmly believes that they are armed with new abilities to be more precise than ever before. An American patient once said to me:

"At home, the doctors leave you in no doubt that they know that any number of things may be wrong with you, and they are

uncertain as to which actually are. Here in Britain one feels the doctor probably hasn't much idea as to all that may be wrong, but he leaves you in no doubt what he's going to do about you."

It is just over 150 years since Sir Henry Halford observed to the Royal College of Physicians of London[1] "The quickness with which a physician of keen perception and great practice makes up his mind on the nature of a disease, and the plan of treatment to be adopted, differs as widely as possible from the inconsiderate haste which marks the decisions of the rash and uninformed." Of course he was speaking at the time when the application of morbid anatomy was ushering in a century of concern with organic disease, which is why he added "to doubt of the existence of a disease because it is not discoverable to the touch, is not only unphilosophical, but must surely in many instances, lead to unfounded and erroneous conclusions." Very soon afterwards if the doctor could not literally feel anything wrong with the patient he felt entitled to ignore the patient's feelings. In the long period that followed people not only became accustomed to hearing the verdict at the end of the examination, but to hearing it expressed with that commanding confidence that is most easily assumed when the doctor knows that whatever he advises will not make any appreciable difference.

From the student's point of view, rapid delineation of a clinical problem, followed immediately by the answer, is a very satisfying and comprehensible situation. A slowly drawn-out process of assessment creates many difficulties, including that of actually being present throughout. A further complication of modern practice arises from the fact that many of the decisions most quickly reached are negative. For example, a cardiologist may reach the conclusion that a patient's breathlessness is unrelated to his cardiovascular system. The student remains, like the patient, anxious to know what the cause of the trouble is, but that is a problem that would not be in the best interest of the patient or the community for the cardiologist to try to solve. It is interesting that while students will forgive an ophthalmologist for concentrating exclusively on sighted patients who have trouble with their eyes, they are less willing to adopt the same attitude to those who practise newer specialties.

Of course none of these problems of teaching and learning are insuperable. They are merely a part of the adaptation of medical

education to contemporary medicine. Students have to be helped to appreciate that especially if they are not following a closely integrated curriculum, learning clinical medicine only becomes easy when they have learned quite a lot of different aspects of it that initially appear unrelated. Clinical method is difficult without some knowledge of people and disease, which in turn is difficult to acquire without some facility in clinical method. In those curricula —and they are many—in which integration is left for the student to achieve for himself towards the end of the course, he requires guidance in writing and from tutors if he is to avoid the temptation to drift passively through the earlier period only to find later that he has nothing very much to integrate. This is all the more important because for many reasons staff-student contact, inside and outside the curriculum, is much less close than it was.

There may be students who are led, by their own nature or by the example of those around them, to involve themselves in original investigatory work to the extent that this becomes their dominant concern. This causes them eventually to become more interested in problems than in people. There are, however, very few such students in Britain. This may be because the system of financing medical care results in the great majority of the clinical teachers carrying too heavy a burden of clinical work. It more probably is due to the fact that the majority of students are primarily motivated to engage in the care of sick people.

The Association for the Study of Medical Education studies of British medical students in 1966[2] revealed that over 44 per cent of new entrants thought the physical aspects of disease would be the most interesting, 20 per cent the psychological aspects, and only 11 per cent thought research would interest them most. Of final year students in 1966 only 4 per cent claimed an interest in research. Similar studies by Donnan in 1975 on first and final year students have shown similar figures.

It does not appear that many of the boys and girls in Britain who wish to go to University are interested in science of any but the most applied kind. In 1974 medicine was, as for many years, far and away the most popular university course to which admission was sought, accounting for 9.6 per cent of all applications. Law remained the second most popular course. Mathematics (fifth), civil engineering (eighth), and electrical engineering (tenth) were the only scientifically inclined subjects, other than medicine,

in the top ten. Dentistry rated thirteenth, physics fourteenth, while chemistry and mechanical engineering shared eighteenth place, each accounting for 1.8 per cent of the total applications.[3]

The evidence is strong that still the greatest problem in British medical education is to enable students to acquire that ability to think scientifically, to reason critically, that will enable them to command their scientific knowledge and prevent them from applying it unthinkingly and automatically. The most successful educational method for achieving this still seems to be the study in depth of a selected scientific subject.

Opportunities for studying a subject or subjects in depth for upwards of a year have been steadily increased. At the same time the range of subjects that may be studied has widened. In Cambridge the range goes far beyond the medical sciences to include, for example, archaeology, philosophy, psychology, social and political science, history of art, Greek history, and numerous others.

Unquantitated observation of Cambridge students joining The London Hospital Medical College over recent years suggests that the subjects commonly chosen fall into three groups: the basic medical sciences, social and political science, the arts and languages. Those who choose a basic medical science appear later to enjoy the clinical course, have no difficulties with it, and later opt for clinical practice as a career, veering more towards medicine than surgery. Those who spend a year in arts or languages are in general slightly less comfortable and successful in their clinical studies, and have difficulty making a career choice. Those who study social and political science for a year not infrequently feel a need for a second year in the same field, and sometimes succeed in obtaining one. They have considerable difficulty in applying themselves to the clinical course, may become over-involved in social work or student politics, and appear to find their interest in the individual patient obscured by their concern for society as a whole. A few opt out of medicine.

In other universities the choice of subjects that may be studied in depth, for that quarter or more of the entry that have the chance, is much more limited. There is evidence, however, to suggest that there are four categories of student. One class, quite small, consists of those who are greatly interested in helping sick people by physical means and not very interested in anything else. Another much larger group is interested in a holistic approach and

in making a positive intervention in the course of disease by varied means. A third, relatively small group is made up of students who seem only interested in the psychological aspects of medicine and can only with difficulty be made to pay attention to any other aspects. The fourth consists of some whose concern for society as a whole is overwhelming, who have assumed that medicine is a panacea for all the ills of mankind and are distressed to find that it is not. Some among them are likely to be much needed. I quote from a letter received recently from a clinical student: "My apparent disillusionment with medicine, as a kind of patch-up job intervening by symptomatic treatment nearer the end-stage than the beginning of illness, is more a function of the growing realisation that I can never fulfill my deepest ambition. This is to eliminate rather than alleviate human suffering. Of course it is a crazy, hopeless, totally irrational ideal but if one considers the starting point of a seven-year-old seeing the world as a sick place which needs cleaning up, and he the saviour, he has a few choices—doctor, priest or politician. As one grows older one may rationalise furiously but still this founder-motive lives on."

While British students today have apparently as great a desire to help humanity as ever their predecessors did and need to acquire a greater command over science in order to do so, they have another problem in that it is not so easy for them to visualise the kind of lives the majority of their patients are living. In 1966 nearly 40 per cent of first year students across the country had fathers graded in Social Class I of the Registrar General's classification. In 1975 the percentage is over 40 per cent. Twenty-two per cent of the students in their first year in ten of our schools had a medically qualified parent. In 1971, Peter Lee during a sabbatical year studied students at The London Hospital Medical College and found that 34 per cent of the class of 1971 had a medical parent, one-third of these parents being alumni. In selecting for that year, four times as many doctors' children were rejected as selected.

Before admission to medical school at between eighteen and nineteen years of age the great majority of British students have done some form of voluntary social work, in, for example, homes for handicapped children or the aged. Many have worked as an auxiliary nurse (about one-third of all entering students are girls) or a hospital porter or in some medically orientated situation. Not many, however, have experienced for any length of time what it is

like to earn a living in any of the occupations to which so many patients are committed, and most young doctors have spent the years from five to twenty-five in *statu pupillari*. In recent years, therefore, some medical schools have encouraged applicants to take a break between school and university and to use it in such a way as to complement their life experience, which so often has been of a sheltered kind. Fifty per cent of those entering The London Hospital Medical College in 1974 had had upwards of a year's break for that purpose. We have now begun studies to see whether this has been helpful to them.

In all countries where medicine can intervene in the course of disease, or health, to an extent never possible before, society, health workers, and students are confronted with new problems as to what to do, or not do, and as to who should decide. The manner in which these problems are tackled within medical education seems to vary from country to country, though in all there is continuing discussion at the local level, within units or between units, whether promoted by students or by teachers. The pattern of Departments of Humanities in medical schools that is emerging in the United States has not been followed in the United Kingdom, where staff appointments for this purpose are few and far between, and honorary. Possibly increased use is made of other facilities by the medical faculty in universities which enjoy a multifaculty campus. More obvious, however, has been the development of organisations of which the London Medical Group is the prototype. Such organisations exist now in some nine major cities. The London Medical Group is an independent, nonpartisan student group for the study of issues raised through the practice of medicine which concern other disciplines. Lectures and symposia (more than 50 per year) are addressed to medical, nursing, and other health students in the twelve London teaching centres and are open to all students and others professionally interested. The Group also organises study seminars and conferences. Topics result from a student critique of previous programmes and the curriculum. Advice is given by a multidisciplinary Consultative Council that includes representatives of other disciplines, such as philosophy, sociology, moral theology and law, as well as medicine. The Group has a small permanent secretariat and is funded by voluntary contributions and support from the medical schools. It has been the origin of the Society for the Study of Medical Ethics, the

Journal of which began circulation this year. This publication without doubt will prove of great value not least to those who form the Ethical Committees that in each hospital and medical school in Britain consider research projects before they are begun. There is no lack of forum in which to discuss medical ethics, but there is no sign of any mechanism whereby the medical profession might come to present any agreed scale of values.

The care of the individual is only one of the issues in regard to which changes in medicine and society have necessitated a reassessment of values and attitudes. There are others. No doubt the relative urgency for reappraisal of each varies from country to country.

In Britain it has for some time become increasingly necessary to rethink our traditional attitude that in all matters of health care the needs of the individual patient must take priority over everything else. This was the attitude instilled into me as student by teachers whose many virtues did not include that of being quantitatively minded. It was rare then to find anyone in British medicine who was quantitatively minded, but no mathematical or statistical expertise was required to see that while the better off got whatever help medicine could give, mostly in their own homes, and the worst off had access to good care in hospital, the vast mass of those in between, particularly women and children, too often lacked the assistance of medicine. Having been brought up from childhood in the midst of an endeavour to provide the first municipal hospitals, acute hospitals for sick poor financed by local authorities, I was at first surprised to find that my teachers seemed to know little of such efforts. They seemed content to do only their bit and do it well. I came to find, however, that in many cases it was not a matter of not caring, but simply that such issues were not customarily discussed with students. There was caring in the profession and a sharing of the widespread national view that more universal access to the relief of sickness and suffering should be provided. Indeed, the profession at that time, was preparing the first blueprint for a National Health Service.

To my generation, therefore, there was nothing in the least surprising about the advent of a National Health Service, after the war in 1948, especially as all the hospitals of the country had been incorporated into an Emergency Medical Service in 1939. Looking back now it seems more daring than it did then, because, after all,

the profession that had been numerically inadequate in the thirties was no larger, but was weary and disorganised. All our 600 hospitals lacked six years of maintenance, many had suffered bomb damage, about half were over a century old, and experienced medical administrators were few and far between. However, the population was healthier than perhaps it had ever been. Furthermore, when a people have just come out on the winning side in a war for which they were hopelessly unprepared, they are perhaps naturally inclined to be a little over-confident about what they can take on. Besides it was after all only a matter of setting out to provide in future for all the people that medicine of the 1930. that in the 1930's only some had enjoyed and to provide it by the same means and through the same pattern of delivery.

No one will ever know whether the National Health Service could have succeeded in achieving its objective, because, of course, almost from the moment of its inception the whole situation changed in Britain, in much the same ways as in most similar countries, but with local flavour and emphasis.

The population began rapidly to increase. In 1939 it was forty-one million. In 1950 a slightly larger population of forty-three million had the right to expect comprehensive medical care, from health services little larger than those of ten years earlier. Since then the population has increased by some fifteen million, with particular increase in the numbers of young and old.

But far more striking, in Britain as elsewhere, have been the qualitative changes in medical needs, demands, and expectations. Not surprisingly the attitude that access to health care is one of the rights of man has led many people to believe that every man has the right to be healthy. Inevitably the past quarter century has seen more demanded of medicine, by more people, than ever before. This would have been the case even if there had been no change in the amount and nature of disease on the one hand, or in the real or believed capacity of medicine on the other.

There have been enormous changes in the amount and nature of disease. Accordingly, the demand for medical care has risen as in all countries that have passed through a period of affluence, for reasons that are not wholly clear but that extend beyond the fact that affluence can lower the threshold for symptoms. In twenty-five years almost everything in our environment has changed along with the life-styles and work habits of most people. While many

have escaped illnesses to which in earlier times they would most likely have fallen victim, others have survived disease that previously would have proved fatal and lived on to become ill again. The daily exposure of most people to sensory assault of all kinds has reached such dimensions as to make one wonder why a state of sensory deprivation should be so great a strain. A generation of British children has been born and brought up in a Britain at peace and yet exposed throughout their lives to violence, at first-hand or secondhand, to a degree unknown to their predecessors, while all around them almost every aspect of life has been up for reappraisal. It is small wonder that, apart from falling ill, people are insecure and more and more in need of help. Nor is it surprising that they turn for help to medicine from which, conscious of its new strength but unaware of its new nature or many limitations, they have ever-growing expectations.

Almost from its inception, therefore, the National Health Service has been attempting to provide for increasing quantities of people a kind of medicine for which it was neither designed nor equipped. Furthermore the new kind of medicine is far more demanding of money and manpower than was the old. It is especially expensive if practised with limited facilities in unsuitable buildings. The Health Service has received ever-increasing infusions of money and staff, but never enough and always, as it were, retrospectively. The rapid provision across the country of contemporary buildings, or for that matter of adequate staff, was impossible. Inevitably, in very many areas working conditions have become increasingly intolerable, not least because in converting old premises it is always easier and more tempting to provide greater comfort for patients than adequate facilities for staff. There have been particular difficulties also in achieving appropriate purpose-built accommodation for general practice because general practitioners have never been in the Health Service. For this reason, medical care has gravitated to hospitals perhaps more than it would otherwise have done.

The production of doctors has been more than doubled in fifteen years by rebuilding a majority of medical schools to about twice their previous size. The number of doctors has been swelled by overseas graduates, many of whom have settled permanently. The total number of general practitioners has remained sufficient to provide one for at least every 2,500 persons, but maldistribution has left some areas short and others overmanned. Meanwhile,

although some hospitals have more staff than others, very few of larger size have sufficient for the work loads they have to carry.

Naturally some time ago it was clear that an inevitable consequence of modern personal medicine would be the advent of community medicine, measurement of the community's needs and resources, as a basis for deciding priorities. Unhappily the development of community medicine, the fashioning of techniques and the acquisition of expertise, has proved far slower than was the development of personal medicine. Only recently has a nation-wide system of posts and departments been established, and the majority of the key personnel are still inexperienced. There has been, however, a remarkable degree of change of attitude in the hospital service towards acceptance of the fact that the needs of the individual have to be matched against the resources of the community.

The growth of specialisation rendered untenable the peculiar British system of internal organisation of hospitals, consisting of a large number of small and totally independent clinical units. A new system has emerged comprised of departments and divisions. It has continued to evolve, partly because it has not been imposed but has been a necessary response to changing conditions and partly because it need not threaten personal independence. It has caused some discomfort as well as some confusion, but with it has come a greater awareness of the whole and of the interrelationship of the various parts. From this it is not so difficult to progress to an awareness of a district or an area or a region as a whole. Unhappily the general practitioner has not yet had this opportunity. As a result, although he is sometimes spoken of as the doctor in the community, he is the doctor who is least able to visualise the needs and resources of the community as a whole. He is still working solely at the level of the needs of the individual patient. Students, on the other hand, seem naturally to grasp the new situation, especially if they are enabled to consider the district or area as a whole in company with those who carry responsibility for meeting its needs. They do not, however, appreciate teaching of community medicine in the abstract. ASME found in 1966 that final year students rated community medicine uninteresting though easy. Donnan[4] this year has found that final year students rated it the least difficult of sixteen subjects in medicine and the least interesting of any save statistics.

It is, of course, abundantly clear that the National Health

Service in Great Britain is not adequately equipped, housed, staffed, deployed, or financed for the work it is trying to do. This fact is disconcerting to those who work in it and to those for whom they work. A rather sudden economic crisis has highlighted the situation that has been further complicated by inept handling of sensitive issues at a time of anxiety. Nonetheless, instead of any feeling of hopelessness, it is possible to sense a growing feeling of very real relief that matters have come to a head at last and that no one need any longer be misled into thinking that one day soon a continuing increase in both personnel and funds will provide all that could be desired. It is as though an era of confused unreality is ending at a time of reality beginning. It is now possible to see how many doctors the country can afford to have, and thus realistically to consider how they might best be used.

In a problem full of variables it is helpful to have some constants, because the problem itself will not go away. It is not possible to provide health care, or reduce the need for it, without some kind of health service that somehow or other achieves a satisfactory relationship between profession, people, and government. It is extremely unlikely that any country could at its first attempt stumble upon precisely the right pattern or any pattern sufficiently flexible to adapt to rapidly changing conditions with ease. The answers to such problems may possibly be obtained by divine revelation, but they cannot be provided by imaginative politicians, or doctors for that matter. They are likely to come only from much study and experimentation, together with the most careful consideration of human values, including evaluation of what a profession is, or should be, of what it must do, and what it cannot do if it is to remain "a profession."

When I was a student, it was very easy to acquire a feeling of belonging, to a firm or clinical unit, to a particular teaching hospital, and to a profession. In a world in which there was an established order of things, not necessarily a good one but to a large extent an accepted one, it was very easy to see the medical profession as a service-oriented organisation of which the primary beneficiaries were the public in contact: patients. It is still possible to see the profession in that light and to see that that, and not the exclusive possession of special knowledge, skills, status, or power, is what makes it a profession and differentiates it from, for example, a business or a trades union. The primary beneficiaries of a busi-

ness are management, workers, and the shareholders. The primary beneficiaries of a trades union are the members of that union. The union exists to get the best it can for its members. There its functions and responsibilities end. No one can expect more from it, and unless or until the traditional functions of a trades union are extended or exploited for political purposes, no one in common sense or fairness should expect more.

A profession is a very different matter. Doctors must in the interest of their patients remain independently-minded persons and yet subject themselves to a corporate discipline that exists not for the good of themselves but of others. The corporate discipline must in the public interest be imposed by the profession, not by the government, for a free medical profession cannot help but be more sensitive to, and more responsible to, the medical needs and pressures of society than can the government. Public, profession, government, all three are interdependent and must be free to influence each other. If the medical profession ceases to be a profession then government has control of all medical care. Government becomes the sole arbiter of what that care shall be, and the public has no source of that independent and informed advice without which it is powerless to influence government, largely because it has no idea in which direction to influence it.

It is, of course, essential that the profession provides its independent and informed advice in a clear coherent fashion—and admittedly this it has not done—in Britain or elsewhere. The fact is that nowhere is the medical profession organised to do so. There has never previously been any real call for it to be what the sociologists would call a commonweal organisation, capable of speaking to society for the good of society on all medical issues. So whenever one fragment of it speaks, another contradicts, and both are suspect of speaking in their own self-interest. Moreover, there has been a very proper reticence, a reluctance to alarm patients by an accurate picture of how dangerously poor some facilities actually are. But it is not impossible to create this new and much needed level of professionalism, capable of providing the clearest possible assessment of objectively acquired evidence.

It could scarcely be expected, however, that in the same twenty-five years that have seen an explosive revolution in medicine, fragmenting it into a series of separate branches, there could yet have been created a new system of unity. Such things take time,

as do the evolution of the most appropriate relationships between government and professions. It is more difficult to find that relationship than to find the most appropriate relationship between government and trades unions. There is no evidence that anyone has yet got near to finding that in Britain.

But, until very recently, despite not knowing how most effectively to do so, government and profession have moved forward together, aware of each other's needs, each conscious of the importance of the other in achieving their joint aim, and determined always to maintain a symbiosis. Government has not sought to destroy the profession's independence or take over the whole of medicine. The profession has remained a profession. It has not been forced into becoming a mutual benefit society, a trades union, or a series of unions instead. It has not abandoned its service orientation in order to take up the defence of its members.

That this has been so must be due to the fact that in the past the individuals who have had the greatest part to play, in government and in the profession, have recognised the importance and complexity of the problem and have approached it with humility and discrimination. There have been periodic troubles arising from inevitable ignorance, but there have not been too many examples of irresponsibility on either side. Profession and government have worked together to a much greater extent and more effectively than generally is realised.

In a democracy, partnership between profession and government is an entirely practicable proposition, if both desire it, but for the partnership to be effective there must be adequate channels of communication between the two and the profession must be able to speak coherently about health care with a voice other than that by which it seeks to conserve its own interests. This is not impossible. Britain, for example, has been fortunate in having ancient Royal Colleges together with a number of other professional associations and universities whose academic freedom has survived dependency on government funds, as well as a National Medical Association traditionally concerned with the welfare of the doctors. The involvement of numerous organisations is, however, inevitably cumbersome, but then democracy is necessarily slow.

Not everyone, of course, finds democracy to his taste, and amongst such people professions are unpopular, particularly a

profession which aims at excellence, is determined and able to give a coherent, informed assessment of society, and declare a scale of values. Yet never has there been so great a need as now for medicine to do just that.

Irrespective of the political persuasion of the government in power, all democracies in modern times are inevitably led from below, wallowing somewhat helplessly in the wake of the great mass of the least informed. There must be many reasons for this, but in times of rapid change the mass media are certainly one reason. They have been the major source of information and attitudes for most people, at the same time remaining themselves materially dependent on the masses and therefore aimed very largely at the entertainment of the majority, particularly the young. It is not easy to be funny 365 days a year, but it requires no great wit or ability, and no courage at all, to mock, particularly to mock those aspects of life that are in the common experience of everyone from childhood onwards. It is easy to make fun of long established institutions. It sometimes is helpful, for satire serves by exposing false pretensions to ridicule. Unhappily, all too often loss of respect for institutions or customs carries with it a more important loss of respect for the values with which they are linked. After twenty-five years there is little left for the media to mock. Whether in consequence or not, there is little left for people to respect and little left for them to trust, save perhaps medicine.

For medicine has not been knocked or mocked—doctors maybe, but not medicine. On the contrary, people have wanted medicine to be more potent. Hope has been a spur to belief. Each successful advance has been eagerly awaited and eagerly announced, often long before it was validated or its implications understood. Expectations have been stimulated and raised year by year, and medicine has been credited with powers it does not possess. Individuals and organizations, while happy to use medicine more and more, are less happy at the thought of so much power in the hands of one group. What medicine should do in many situations is, they say, too important a question to be left to doctors alone to answer. Many doctors would agree, but they find that most patients, even those anxious to be consulted about medical decisions or other people, are reluctant to take major decisions about themselves and, indeed, only too willing to hand over responsibility for their own health to their medical advisers.

It is important that the true scope of this overestimated power of medicine should be more accurately understood by the public, but even more important that a profession that can still command some respect should state its values. It would be an exaggeration in Britain, at least, to say any semblance of its past order has been removed from our society and wrong to say its past order was wholly good. We do seem, however, to have reached a situation in which it is possible to see that no order at all is the worst of states to be in. There is no denying that there has been a considerable and widespread erosion of standards aud moral values. There is little doubt that this is all the more serious for not having been deliberate. There is no one enemy responsible who can be easily identified and effectively neutralised.

In such times it is natural that individuals and groups put themselves first and seek to secure their own interests at all costs. It is easy also to come insidiously to accept that any end can justify the means, an acceptance that comes nearer as we fail to ensure that any cause is tarnished beyond redemption if in its name indiscriminate death and mutilation are loosed among the innocent and unsuspecting by evil fanatics who cowardly exploit the safety of our urban society.

At such a time medicine should speak and declare values based on existing knowledge of man. It could not speak coherently, however, unless in addition to being a service-orientated organisation, serving the public in contact it made itself capable of being also a commonweal organisation serving society as a whole. This it could do and speak coherently, but no one will listen unless it remains a profession, and that it will cease to be if it takes strike action. Therefore, little can be more important in medical education today than the inculcation of an understanding of what a profession is and of a determination to maintain true professional status. That this can be done is shown by the fact that in Britain in the last two weeks only, a few of the sorely tried and previously exploited junior doctors have gone on partial strike.

The purpose of medical education is, through doctors, to improve the quality of life in the future. Its responsibility is great because inevitably its effects will, if only by default, spread far beyond the care of the sick. Whether or not the doctor should be concerned with the moral as well as with the physical, chemical, psychological, and social health of his patient, medicine will affect

the moral welfare of mankind. Yet the only certainty in medical education is uncertainty. Around the small area of recently expanded medical knowledge spreads an endless expanse of ignorance and even the knowledge we have is fallible. Questioning, probing, testing by trained intellects must continue. Doubt must remain. In such uncertainty we have no alternative but to make ideals our basis of realism. We have to set excellence as our goal because if we cease to seek for excellence we must fail in our purpose and the future will be left to take care of itself.

There are of course those who believe that the future should be left to take care of itself. The Vice Chancellor of London University, Sir Cyril Philips, wrote recently[5]: "In an egalitarian society the movements of the multitude, blind and unpredictable, are not seen as being guided by the will of any individual. On the contrary, humanity seems always to advance of itself." He went on:

"Hope for the human future lies not in acceptance, not in avoidance, but in a positive repudiation of such views; and in the knowledge that men and women differ from all those species which have previously become extinct because, through their conceptual ability, they can see where they stand on the evolutionary path.

"They can in fact if they will, we can in fact, if we will, invent the future and pull ourselves into it. And one of the strands of this rope of time is the vision of greatness and excellence."

I believe we have in medical education to try to instill an unquenchable desire for the attainment of excellence, an excellence that will never be achieved by those who seek it, who will be rewarded for their search mainly by a sense of duty done. At a time when in many countries medical schools can take their pick of the brightest and best of youth, it should not be so difficult to instill such an aim. But it is not enough that the hearts and minds of the young should aspire to great things for even if they continue to do so with courage and persistence they will achieve little if, without knowing it, their standards of what is excellent are too low.

They must know what in their time is the best. Therefore in medical education the best must be demonstrated, and evaluated and then bettered. Therefore in and around medical schools there must be practice of a higher quality than anywhere else.

Naturally in a time of widespread inequality there are many people who see as their primary purpose the achievement of

equality now. Usually that is possible only by taking from those who have the most and giving to those who have the least. Such a policy is advocated in some quarters in the field of hospital medicine in Britain today, and quite frequently in other countries. It could result in the achievement of equality in the provision of hospital care across any country. It would also result in uniform inadequacy and prevent the demonstration of quality on which the success of medical education inescapably depends. The same policy would have the same effect if applied to any kind of community health services. It has therefore to be resisted, and the most powerful weapon of resistance is public awareness of the inevitable lowering of standards it would bring in the long term.

I quote again from Sir Cyril Philips:

"So in the hard times of this life, when men and women search their hearts, and perchance come face to face with the cold inimical and pitiless universe, we are nothing if we do not lift our eyes and nothing if we do not proclaim our unquenchable human and corporate spirit, we are nothing if we do not seek to be excellent and great.

"And part of the seeking in a university is to present the vision of greatness."

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